SECTION 12.
SURGERY

PROCEDURE CODES

Missouri Medicaid recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

SURGICAL MODIFIERS

Missouri Medicaid uses the following CPT modifiers for surgical procedures.

50 - bilateral procedure
54 - surgical care only
55 - post operative management only
62 - two surgeons
80 - assistant surgeon
SG- Ambulatory Surgical Center only (facility services)

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a Medicaid reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

There is no post-operative period associated with burns or endoscopy procedures.

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 14 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery “incidentally” performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the Medicaid *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone, for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same recipient, on the same date of service, by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

100% of the allowable fee for the major procedure
50% of the allowable fee for the secondary procedure
25% of the allowable fee for the third procedure

An operative report should always accompany claims with multiple surgical procedures on the same recipient on the same date of service.

CO-SURGERY

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic Medicaid provider number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service. Consultation procedure codes are listed on the following page.

CONSULTATION CODES

Office/Outpatient Consult Codes	In-patient Consult Codes
99241	99251
99242	99252
99243	99253
99244	99254
99245 (requires a copy of the consult report with the claim)	99255 (requires a copy of the consult report with the claim)

Follow-up inpatient consultations (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent visits requested by the attending physician.

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is

the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents and nurse practioners are **not** permitted to provide the first, second or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.

- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.

- Those surgical operations specified are exempt from the second surgical opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.

- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter "emergency" in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.

- If the recipient was not Medicaid eligible at the time of service, but eligibility was made retroactive to the date of surgery, the provider should indicate "RETRO ELIG" in field 19 of the CMS-1500 form to indicate that the recipient was not eligible on the date of service but became eligible retroactive to that date. A letter from the Family Support Division county office must be attached to reflect eligibility dates.

SURGERY CODES THAT REQUIRE A SECOND OPINION

The following procedure codes require a second surgical opinion and the submission of a Second Surgical Opinion" form. Procedure codes marked with an "*" also require the submission of an "Acknowledgment of Hysterectomy Information" form.

28290	49491-50	49570	58260*	63003-62	63048
28290-50	49491-62	46570-50	58260-62*	63005	63048-62
28292	49491-6250	49570-62	58262*	63005-62	63055
28292-50	49495	49570-6250	58262-62*	63011	63055-62
28292-62	49495-50	49580	58263*	63011-62	63056
28292-6250	49495-62	49580-62	58263-62*	63012	63056-62
28293	49495-6250	49585	58267*	63012-62	63057
28293-50	49500	49585-62	58267-62*	63015	63057-62
28293-62	49500-50	49650	58270*	63015-62	63064
28293-6250	49500-62	49650-50	58270-62*	63016	63064-62
28296	49500-6250	49650-62	58275*	63016-62	63066
28296-50	49505	49650-6250	58275-62*	63017	63066-62
28296-62	49505-50	49651	58280*	63017-62	63075
28296-6250	49505-62	49651-50	58280-62*	63020	63075-62
28297	49505-6250	49651-62	58285*	63020-50	63076
28297-50	49520	49651-6250	58285-62*	63020-62	63076-62
28297-62	49520-50	49659	58290*	63020-6250	63077
28297-6250	49520-62	49659-50	58290-62*	63030	63077-62
28306	49520-6250	57240	58291*	63030-50	63078
28306-62	49525	57240-62	58291-62*	63030-62	63078-62
28308	49525-50	57250	58292*	63030-6250	63081
28308-62	49525-62	57250-62	58292-62*	63035	63081-62
47562	49525-6250	57260	58293*	63035-50	63082
47562-62	49550	57260-62	58293-62*	63035-62	63082-62
47563	49550-50	57265	58294*	63035-6250	63085
47563-62	49550-62	58265-62	58294-62*	63040	63085-62
47564	49550-6250	58120	58550*	63040-50	63086
47564-62	49555	58150*	58550-62*	63040-62	63086-62
47600	49555-50	58150-62*	58552*	63040-6250	63087
47600-62	49555-62	58152*	58552-62*	63042	63087-62
47605	49555-6250	58152-62*	58553*	63042-50	63088
47605-62	49560	58180*	58553-62*	63042-62	63088-62
47610	49560-50	58180-62*	58554*	63042-6250	63090
47610-62	49560-62	58200*	58554-62*	63045	63090-62
47612	49560-6250	58200-62*	59525*	63045-62	63091
47612-62	49565	58210*	59525-62*	63046	63091-62
47620	49565-50	58210-62*	63001	63046-62	63180
47620-62	49565-62	58240*	63001-62	63047	63180-62
49491	49565-6250	58240-62*	63003	63047-62	63182

63182-62	63191-62	63196-62	66840	66852-6250	66984
63185	63191-6250	63197	66840-50	66920	66984-50
63185-62	63194	63197-62	66850	66920-50	
63190	63194-62	63198	66850-50	66920-62	
63190-62	63195	63198-62	66852	66920-6250	
63191	63195-62	63199	66852-50	66983	
63191-50	63196	63199-62	66852-62	66983-50	